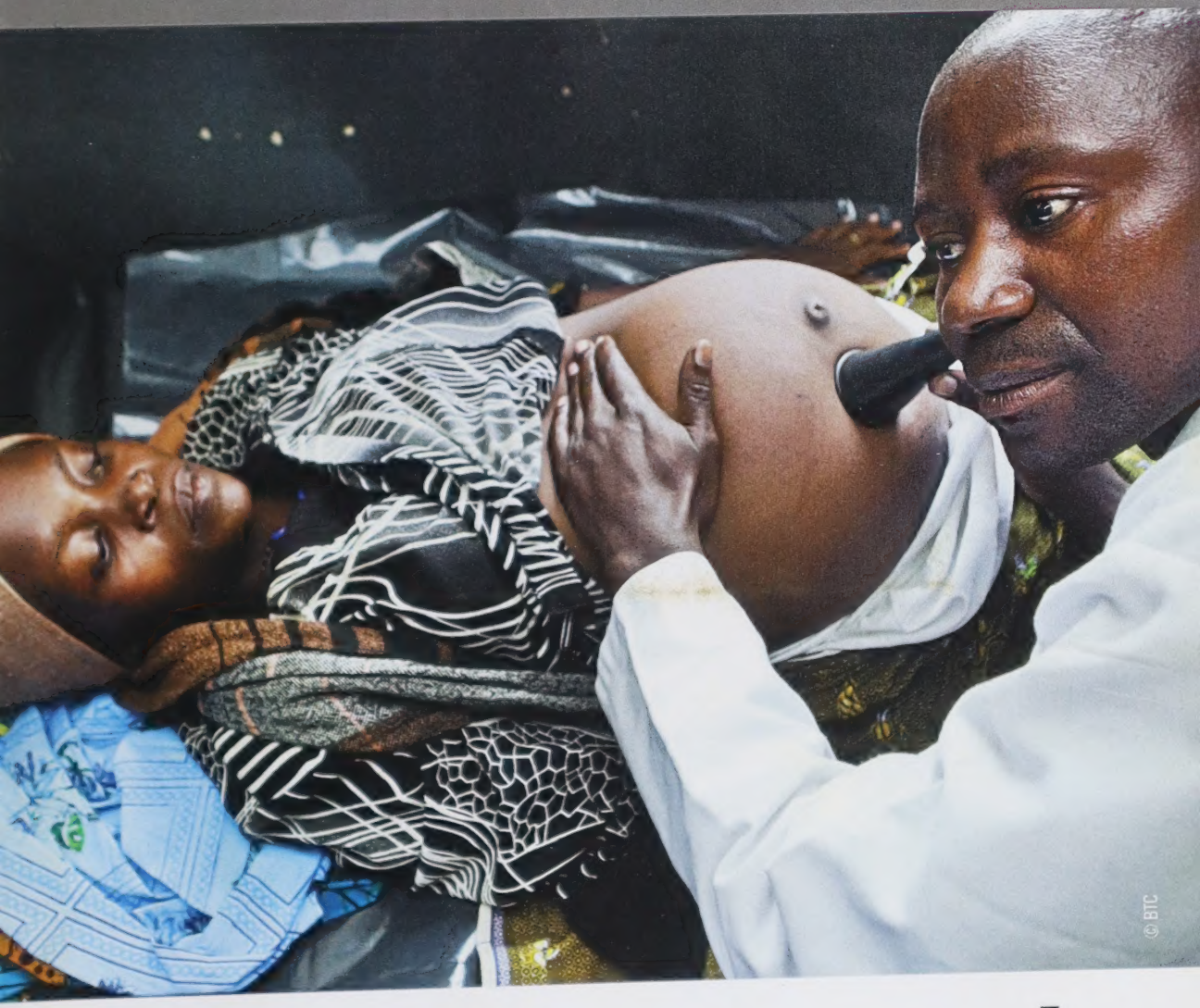
Policy Note

The right to health and healthcare



THE BELGIAN
DEVELOPMENT COOPERATION

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Policy Note

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Drafted by DGD in collaboration with the Working Group on Health and the Be-cause Health Platform

and

approved by the Minister Mr. Charles Michel

in

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Health and healthcare

Health is a state of complete physical, mental and social well-being. It is not merely the absence of disease or infirmity (WHO, 1946[1]). Access to quality healthcare is an inalienable right and an essential element in the fight against poverty and inequality.

During recent years, increased international interest in the health sector has translated into improved strategic planning and more financial resources for health. Partner countries that drafted a poverty reduction strategy paper (PRSP), or a similar document, placed much more emphasis on social sectors, mainly health and education, partly also with support from donors. The increased attention of donors to health is clearly reflected by the huge increase in ODA (Official Development Aid, ODA), from $ 6.8 billion in 2000 to $ 17 billion in 2006 (Global Monitoring Report 2008[2]). These funds were largely generated through a growing number of new global health initiatives that focus on fighting specific diseases: The Global Fund To Fight AIDS, Tuberculosis and Malaria (GFATM), The United States President's Emergency Plan for AIDS Relief (PEPFAR), The World Bank's Multi-Country AIDS Program (MAP), The Global Alliance for Vaccines and Immunization (GAVI), etc. Also, public-private partnerships offer the possibility of developing much-needed new drugs against neglected (tropical) diseases. The focus on disease control has led to significant progress in many domains.

The aid architecture in the health sector has changed significantly with the increased focus on the funding of control specific disease and the relatively lower share of aid for the health system. But now a change in this approach can be observed. Belgium, which has always emphasised the universal right to health as a means of poverty reduction, now holds the opinion that the development of an efficient and sustainable health system able of providing reliable healthcare for all, is the best means to achieve this objective. This requires collaboration between partner country and donors, beyond dogmas and traditional divisions between horizontal and vertical approaches.

The aid paradigms themselves have changed in recent years and the role of development aid has been redefined. There is now much more attention paid towards ownership of the development strategy by the partner country and the need for greater effectiveness of aid. With this background, this paper doesn't pay only attention to the specific characteristics of cooperation in the health sector but does also refer to systemic requirements for effective aid, such as alignment with the partner country's own poverty reduction strategy, the use of the country's own channels for implementation and better harmonization between the various donor agencies that are active in the country.

Six years after the strategic note on 'Primary Healthcare' (2002) was outlined, this new paper is based upon the new aid architecture and paradigms, the evaluation of the health sector[3]

1 WHO (1946). *Constitution of the WHO*. Adopted by the International Health Conference held in New York from 19 June to 22 July 1946.
2 World Bank (2008). *Global Monitoring Report 2008*. World Bank, Washington DC.
3 HERA, ALTER and ETC (2005). *Evaluatie van de gezondheidssector van de Belgische Ontwikkelingssamenwerking*. (Evaluation of the health sector of the Belgian development cooperation).

and particularly the discussion paper of Be-cause Health[4], the result of a participatory process involving all Belgian key players in international cooperation. The paper has been prepared as a guide for Belgian decision-makers, advisors in development cooperation and all other people involved in political dialogue on health policy at local, national and international level.

In a first part (1) the paper underlines the need for a multi-sectoral approach to health. Section two (2) outlines the role of a sector wide approach in healthcare. The following part (3) is devoted to the main challenges of the health systems in the current aid architecture. The fourth part (4) gives an account of Belgium's commitments at international level forming the overall strategic framework of this paper. Based on the two last chapters and taking into account the comparative advantages of Belgium, a number of principles are set out in section five (5). A final section (6) discusses the practical operational details of Belgian cooperation in the sector.

4 Be-cause Health (2007). *Cadre conceptuel de la coopération belge en santé: «Investir dans la santé pour un meilleur bien-être»*. This is conceived as a dynamic and participatory reference document.

1. The right to health, a multi-sectoral approach

The development policy of a country should focus on social and economic development of all of its citizens, whilst respecting their rights. Aiming this, a partner country may request the support of the international community. During the last few decades, the international community has become more and more aware that «development» and «progress» are not only characterised by economic progress or income per capita, but also in terms of opportunities of every individual for personal fulfilment. These opportunities range from the very basic such as enough food, clothing and housing, to more complex elements such as the opportunity to participate in political activities and having positive self-esteem. More and more aspects of human life are thus included in the evaluation of development. For example, the Human Develop-ment Index[1] does not only include per capita income (GDP), but also life expectancy and education. The Millennium Development Goals (MDGs) of the United Nations doesn't aim only at reducing inequality of income, but also at improving health, education, gender equality, and environment (drinking water).

The right to health appears to be a recurrent element, which is not surprising as health is pre-eminently a holistic and multi-sectoral issue. For example, a mother's educational level has a significant effect on the health of her child (children). A lack of drinking water or decent housing leads to health problems. Armed conflicts, migration, natural and environmental disasters obviously have a devastating impact on health[2]. Also, climate change risks to have a significant impact on health, most of all in the poorest countries. In addition, health affects various fields and sectors. Children's health influences the extent to which they can acquire knowledge and remember information. Health has an important impact on economic development by the enormous influence of absenteeism and efficiency in the labour force (see for example the impact of the HIV/AIDS epidemic). Many families find themselves in a poverty trap because of high expenditures for private medical treatments (the so-called out of pocket payments). Demographic growth and the health costs it involves might place a heavy burden on the country's budget in times of stagnant economic growth and low tax revenues. Therefore the development of a health system should be part of a development strategy promoting intensive growth, which leads both to improvements in the health and physical welfare of the poorest populations.

A broad and multi-sectoral approach to sustainable development, with health features as a key factor, is therefore central to the policy of the Belgian development cooperation. This process could also be stimulated by paying more attention to cross-cutting issues as gender, environment, human rights and children's rights. Depending on the country's priorities, the focus of other donors and comparative advantages of Belgium, the cooperation should focus on priorities in sectors or sub-sectors which contribute significantly to human development. Aside from health, these priorities might be found in education, drinking water, sanitation, nutrition, housing, transport, infrastructure and energy, environmental management, personal safety and conflict management, culture, women and children's rights, etc[3]. At the same time, a balance must be struck between social and economic progress, with the emphasis on environmental sustainability and equal opportunities.

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1 Some consider the Human Development Index as an operational translation of the capability approach by Amartya Sen.

2 The report «Closing the gap in one generation» of the «Commission on social determinants of health» of 2008 convincingly made the link between social justice, health and quality of life. www.who.int/social_determinants/final_report/en/index.html

3 Therefore this paper should be read parallel to the other sectoral and topical policy papers.

Within this context, the universal right to access to high quality healthcare plays a major role in the pursuit of health. In this paper we will deal with the sectoral approach that is needed for achieving this goal.

2. The right to healthcare, a sectoral approach

2.1 Some definitions

During the drafting of this paper, it became clear that there was some confusion when using various notions. This confusion reflects a real situation in which the boundaries between sectors and systems are not always clear. The definitions below are essentially based on the WHO's definitions. Above all, they are pragmatic and aim to provide this paper with the clearest possible structure whilst using and clarifying the concepts in context.

- **The health system, a multi-sectoral concept**

Since the year 2000, the WHO has defined the health system as follows, «activities whose primary purpose is to restore, improve and maintain health». This definition includes adaptations made to school programmes to cover AIDS prevention, but not the education sector as a whole, which does not prevent education, together with other sectors, organisations and institutions from broadly contributing to improving health. Alongside healthcare services in the stricter sense, this inter-sectoral approach is important for optimising results in the health domain[1].

- **The health sector, a sectoral concept**

A **sector** may be defined as follows: (1) a socio-economic domain which produces specific goods and/or services, (2) a strategic domain or (3) a set of results. Furthermore, the characteristics of a sector may reveal major differences depending on the context; the main elements being the role of the public authorities, the existence or the absence of sector-wide planning, a budget and a result-oriented approach.

Without losing sight of the aforementioned contextual differences, the health sector may be defined as the strategic domain in which the public authorities take on clear responsibility for financial matters as well as that of a service provider and regulator in matters regarding health. Ideally, this responsibility translates into a concerted set of strategic objectives, planning, coordination, results and dialogue, which is largely supported by other players. Within the institutional and budgetary framework of a national healthcare policy, the partner country and the potential donors aim to see a consistent set of results responding to the health needs of the population on various strategy and implementation levels (macro, meso, micro).

- **The healthcare system, essential element in the health sector**

The healthcare system is the whole range of institutions, people and resources that ensure that (high quality and accessible) healthcare services are provided to the whole population in all instances.

The very subject of this paper is the health sector and its healthcare system. With this background in mind, the paper avoids the vague and improper use of the expression «health system», which is at the root of the majority of the confusion.

1 See also the concept paper of Be-cause Health 2007 mentioned above.

Three major groups of key players make up the health sector: the public authorities, private initiatives and non-profit organisations. All three have their own specific importance and international cooperation must take this into account. Therefore, when acquiring medicines, the poorest in the partner countries largely depends on the informal or formal free market. Private capital may cover a share of the (sometimes heavy) investments in the sector and contribute towards the provision of services. In some countries and regions, non-profit organisations in turn play a pivotal role in terms of supplying health services, developing local capacity and giving critical feedback on the effects of the health policy on the population. The specific role and added value of each key player differs from country to country and also changes over time. Ultimately the healthcare as a system is designed by the standards set by the public authorities, the role that they play in distributing financial resources and materials, their fundamental control over the quality of healthcare and access to it.

2.2 The role of public authorities

Public services play an important role in supplying the collective and public good that healthcare represents. Four universal principles justify the role of public authorities as a planner and organiser in the healthcare sector. Each one may represent an obstacle and require the official policy to be amended or strengthened.

- Equity[2] in accessing healthcare: the provision of a minimal guarantee in terms of accessing universal healthcare is a powerful mechanism of redistribution, especially when there is large-scale inequality in accessing general means of production such as the land, credit or work. It also falls upon the public authorities to pay particular attention to the individual needs and rights of women and children. Poverty and exclusion often have a gender dimension which must be taken into account in the healthcare policy.

- Right to correct information: the healthcare sector is characterised by an asymmetry between the patient and the healthcare provider, which places the patient in a weaker position and may lead to the contracting of one avoidable illness or another, to unfounded fears or to wrong decisions being made during diagnosis and treatment. This asymmetry may also generate dishonest practices, for example, invoicing costly and/or unnecessary treatments or deliberately mixing science with superstition, whilst serious healthcare providers do not succeed in having their good intentions valued in a credible manner. Intervention from public authorities in terms of awarding diplomas, implementing salary legislation, organising healthcare inspections, training and distributing information in order to prevent and combat diseases, in addition to controlling medicines, are all examples of how public authorities can protect and inform the patient.

- Protection from financial risk: in the event of a serious health problem, costs of healthcare can quickly spiral upwards and even become impossible to pay; the person suffering will not resort to care when the costs will plunge the family into (even more) poverty. By setting up a social security system (the so-called Beveridge model), based on mutual funds (the Bismarck model) or otherwise, the public authorities carry out

2 Full equality in access to care is virtually impossible, but equity should be possible: e.g. it is not possible to physically supply the same services to indigenous people in the Amazon as to the urban population, but one can try to provide equivalent care that meets their needs.

risk sharing by distributing the costs over the whole population so that each individual benefits from the right protection against major risks for a relatively low cost per person.

- Seeking general well-being: given that individuals are often unaware or do not taken into account the negative effects of their illness on others (so-called «external effects»), they often do not make enough effort to avoid the illness or seek care if they do not consider it necessary. This attitude may be detrimental to society; more people may fall ill. A government which aims at the population's general well-being however will take into account this societal impact in its healthcare policy and will make optimal social efforts. At national level, public intervention will come in the form of, for example, vaccinations, combating epidemics and an environmental policy. At global level, research into medicines (a universal public good) is under-financed because the positive external effects are not taken into account.

In an environment where resources are scarce and needs are mainly not satisfied, the aforementioned principles gain even more importance in the fight against poverty. As such, it falls to the public authorities to bring their sectoral policy, in this case healthcare, into the scope of the national plan to eradicate poverty, and to include budgetary discussion, inter-sectoral dialogue and dialogue with donors. The way in which they perform their role may vary: from minimal intervention, including conferring licences or drafting quality standards, to developing a proper public healthcare system.

3. Challenges for the health sector and its healthcare system

Despite the results observed, increased financing for combating certain diseases might threaten general efforts to address the population's general health needs. And yet, the health sector's main mission is to develop a healthcare system which offers global high quality healthcare on an effective and sustainable basis and which responds to the needs of all strata of society. In order to ensure that the results are satisfactory, all key players must assist the partner country consistently and as much as possible.

3.1 Main challenges for the health sector

The main problems of the health sector in recent years include:

1. The growing complexity of the international aid architecture in the health sector is increasing the pressure on national and local health administrative bodies which are already weak. All new donors have a tendency to introduce their own models and cycles in terms of budgeting, financing, monitoring and evaluation. This often results in parallel systems being set up without taking into account the existing mechanisms in partner countries.

2. The lack of ownership at (inter)national, regional and local level is a hindrance to the sense of responsibility and the flexibility of both people at administrative level and health workers. The pressure exerted by some donors to include priorities or strategies in a sectoral plan undermines local ownership of the plan. Furthermore, a culture of far-reaching centralisation of decision-making and implementation processes prevents a move towards more ownership at regional and local level. Experience locally has taught us, however, that the quality of healthcare improves if the patients, local communities or specific target groups (women and children, poorer sections of population) have more of a say in the matter in terms of organising healthcare, for example, times and rates of consultations, monitoring chronic diseases, pre-financing through mutual funds and participating in decision-making bodies. This requires a new institutional culture and a new model for allocating roles, not only in partner countries but also from donor organisations.

3. The lack of a realistic national sectoral health plan equipped with a consistent operational and financial component in certain partner countries. Such a plan with clearly defined objectives is however a key condition for achieving lasting cooperation between partner countries and donors.

4. Under-financing and the need for a sustainable and predictable budget with consistent allocation of means. Chronic under-financing in the health sector, caused especially by the «Structural Adjustment Programmes» of the 1990s, led to the dismantling of public health services and made healthcare inaccessible to large layers of the population. Despite an increase in financial means directed towards healthcare, current concentration, too focused on certain diseases, has produced undesirable collateral effects. More consistency is required in the health sector in order to increase the effectiveness of aid. Furthermore, short term financing cycles (for 3 or 5 years) make it particularly difficult to plan in the long term and to have continuous and stable financing.

5. Lack of internal consistency in the use of different aid channels by donor countries
   Many donor countries do not always use the different domestic aid channels and instruments available in an optimal manner. It is commonplace for their multilateral, bilateral, direct and indirect aid as well as institutional and humanitarian intervention to overlap. The particular nature and specific role of each key player must not prevent them from seeking reinforced consistency. The partner country can only benefit from cooperation with a donor whose various channels support each facet of its development process in an organised way.

3.2 Main challenges for the healthcare system

1. Quantitative and qualitative human resources deficiency[1].
   The effectiveness of the healthcare system is largely determined by the quality and quantity of health workers[2], in institutional as well as healthcare terms. The chronic shortage of human resources, especially in Sub-Saharan Africa, is caused by a brain drain due to external (emigration) as well as internal migration (from rural areas into towns and cities, from an operational role into an administrative one), insufficient education, inequality between women and men, low salaries, bad working conditions and excessive administrative costs. This deficiency results in a limited use of aid. In Ethiopia, for example, only 15 to 20 percent of external funds are used due to a human resources deficit (Global Monitoring Report 2008)[3].

2. Underestimation of the impact on healthcare of major infectious, neglected or new diseases. The persistence of major infectious diseases such as HIV/AIDS, malaria and tuberculosis, the neglect of certain infectious diseases and the emergence of new diseases affect healthcare on two fronts. On one hand, demand for healthcare is increasing and services are increasingly required; on the other hand, services' capacity is decreasing because healthcare staff is also affected. In countries with a high prevalence of HIV/AIDS, this epidemic is undermining the running of healthcare services.

3. Poor quality and limited use of healthcare services. Healthcare services are in many places in a poor condition, and access to healthcare often remains restricted due to geographical, financial, psychosocial and cultural barriers. Women and teenagers are the first to suffer from insufficient services. The poor technical and relational quality of care offered and the negative behaviour of the demotivated personnel in the public sector, forces the population to seek alternatives in the formal and less formal private sector.

4. Insufficient availability of essential pharmaceutical products[4]. Medicines, vaccines, medical equipment and diagnostic means are not sufficiently available and/or are of dubious quality. Insufficient checks are carried out. Research into new medicines for untreated diseases is insufficient.

As already indicated at the beginning of this paper, the health sector does not evolve in a vacuum. An unfavourable macro-economic context, conflict, social problems, climate change, difficult trade relations and intellectual property negotiations also serve to complicate the development of a sustainable healthcare system.

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1 Seminar Human Resources (Be-cause Health 2005): «Human Resources for Health. Confronting complexity and diversity», background information on HR problems in developing countries. See www.be-causehealth.be.
2 In a telling formula: 1 FTE (Full Time Equivalent) = presence x motivation x competence.
3 World Bank (2008). *Global Monitoring Report 2008*. World Bank, Washington DC
4 «Drugs, cure or curse». Recommendations. Seminar Be-cause Health, December 2007

4. The international reference framework

The Belgian strategy on health is in line with the framework of commitments made by Belgium at European and multilateral level:

4.1 The Alma Ata Declaration

In 1978, the World Health Organisation and its Member States adopted the declaration «Health for all»[1]. The objective of this declaration was as follows: by the year 2000, all individuals were expected to have attained a level of health which would allow them to lead a social and economic productive life. Primary healthcare (PHC), considered the key to reaching this objective, was defined as follows:

> *Primary healthcare is essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing healthcare as close as possible to where people live and work, and constitutes the first element of a continuing healthcare process. (Declaration of Alma Ata §VI)*

In 1998, the World Health Assembly ratified the Declaration of Alma Ata for the 21st century. The importance of this Declaration was highlighted again at its thirtieth anniversary by the World Health Report (WHR) in 2008: «Primary Healthcare: Now More Than Ever»[2]. Earlier, in 2001, Belgium also launched the Antwerp Declaration: «Healthcare for All» (see annex 1).

4.2 The Millennium Development Goals

The dawning of a new millennium presented an opportunity to reformulate the major challenges of sustainable development in the form of eight millennium goals. The critical situation in healthcare is recognised within it and three of the eight goals particularly concern healthcare: reducing infant mortality (4), improving maternal health (5) and combating HIV/AIDS, malaria and other diseases (6).

The mid-term review of the MDGs revealed that despite the significant progress that has been noted, these goals are unlikely to be achieved (Global Monitoring Report 2008), in particular those related to gender aspects[3].

1 www.who.int/publications/almaata_declaration_en.pdf
2 www.who.int/whr/2008/en/index.html
3 http://diplomatie.belgium.be/en/binaries/women_go_beyond_the_millennium_goals_en_tcm312-65178.pdf

In recent years, achieving the millennium goals has been one of the main reasons behind launching initiatives to combat specific diseases. It is, however, important to place these goals in a broader context and to highlight that they are the symptoms of wider health-related problems facing developing countries. For this reason, a holistic approach from the sector may turn out to be more expedient. The universal right to health is considered a sustainable means of achieving the millennium goals. The addition of a new target under goal 5 «Achieve, by 2015, universal access to reproductive health» is an important step in this direction. Belgium actively supported this development and in 2007 published a political paper on «the Belgian development cooperation in the domain of sexual and reproductive health and rights».[4]

4.3 The DAC Paris Declaration

In 2005, Belgium signed the Paris Declaration on Aid Effectiveness. This decla-ration contains an ambitious agenda which, between now and 2010, aims to increase the impact of development aid thanks to the promotion of more effective partnerships between donors and partner countries. The declaration is based on five commitments: ownership, alignment, harmonisation, results-oriented management and mutual responsibility. The follow-up conference confirmed these commitments in September 2008 in Accra and led to the drafting of an action plan, the Accra Agenda for Action (AAA), which establishes the mechanisms for achieving tangible results between now and 2010.[5]

4.4 The EU Code of Conduct on Division of Labour

In order to further increase the effectiveness of the aid, in 2007, the European Commission drafted a code of conduct aimed at improving the division of labour between European donors in partner countries. The code specifies that Member States have to focus their activities on a limited number of priority countries. In these priority countries, donors must, depending on their comparative advantages, specialise in three sectors on which to focus the aid. In the sectors that are not considered priority, donors must round off their activities and eventually take them up again in a silent partnership with another donor. In this way, the Commission is planning to limit the presence of active European donors to a maximum of five donors per sector between now and 2010.

4 http://diplomatie.belgium.be/en/binaries/policy_paper_sexual_and_reproductive_health_tcm312-65632.pdf
5 http://siteresources.worldbank.org/ACCRAEXT/Resources/4700790-1217425866038/AAA-4-SEPTEMBER-FINAL-16h00.pdf

5. Main lines of force for a response from the Belgian cooperation – challenges within the health sector and the healthcare system

Given the major challenges in the health sector, the Belgian cooperation on health outlines a response which draws upon the strategic framework described above. As such, the essence is laid on modalities for sectoral aid in the health sector and on the reaction to the specific problems in the healthcare sector. The fundamental human right to health and healthcare is the point of departure for this approach.

5.1 The health sector: modalities for sectoral aid

1. Alignment, partnership and harmonisation: balancing instruments in he face of increasing complexity of the international aid architecture

Belgians support to intervention in partner countries follows the national priorities («political alignment») and specific systems in the partner country («systemic alignment»). With the aim of establishing a healthy partnership, a constructive but also critical attitude must be adopted («critical alignment»[1]) towards the partner country and must take into account Belgium's comparative advantages. In the case of states in fragile situations, the donor even considers not using public systems but instead seek the greatest possible compatibility between its own way of operating and these public systems ('shadow alignment'). The appropriate aid modalities vary. There may be general or sectoral budget support, basket funds, programmes, projects, or a combination (portfolio). Regardless of the modality/-ies chosen, they have to add value for the whole sector.

Cooperation with key players from civil society constructively reinforces the democratisation. The dialogue and cooperation with national partners which recognise that ultimately the responsibility lies with the partners should lead to tailor-made and lasting solutions as well as better concordance between supply and demand.

Several efforts have been made to achieve the harmonisation and simplification of various administrative and financial procedures in collaboration with other donors. Priority interventions reinforcement of capacity, institutional support and decentralisation of planning, implementation and evaluation vis-à-vis the target groups while being flexible in the way of operation.

1 Some think that in exceptional circumstances and in view of public well-being even a «critical non-alignment» may be appropriate as the most constructive contribution to the national policy.

Belgium's comparative advantages in the health sector :

- Long experience in the health sector, mainly in supporting district health systems, humanitarian aid, policy development and in integrated diseases control activities.
- Tradition of working and thinking geared towards the system.
- The existence of a 'Belgian school' of international public health with a good reputation.
- Existence of a network (bilateral, multilateral, civil society) of experts which is increasingly recognised in the international debate.
- High-quality and structured interaction between the various key players in cooperation in the health sector (e.g. Be-cause Health).
- Presence of Belgians in key positions in international organisations.
- Experience of a private social security and healthcare insurance systems based on the mutual fund system.
- Experience of pioneering finance systems (e.g. micro health insurance).

2. Strengthening ownership at (inter)national, regional and local level

Partner countries bear the prime responsibility for their development of strategies and programmes. The creation and maintenance of an endogenous procedure are achieved through large-scale ownership across all strategic levels. Sectoral notes, poverty reduction plans (e.g. PRSPs)[2], or similar documents defining the country's policy in the health sector act as a point of departure. Potential inconsistencies between the documents at different levels come to light and are corrected. It must be kept in mind that the strategy used is not always supported at intermediary or local level and that the critical contribution from civil society varies enormously. It is therefore important to consult these levels so that their needs and expectations can be taken into account and so that they too can develop a sense of ownership. This approach also conforms to the principle of subsidiarity which advocates maximum interaction between the citizen and the decision-making process and its execution. The lesser-represented target groups - women and poorest of the population - also need to have their voices heard, above all when the intervention directly affects their needs and rights. This is how a broad democratic foundation is created.

3. A result-oriented health plan for long term commitment

A realistic and well designed national health plan is an essential tool when establishing firm and lasting cooperation between a partner country and the donors countries. Donors must not be obsessed by drafting to the very last detail the 'perfect' plan aimed at reaching an ownership, alignment and harmonisation process. A sectoral plan is also a flexible instrument for permanent dialogue and regular evaluations of the results obtained and for the adjustments of methods and objectives. It is important to remain open to using new and more flexible (less mechanical) methods for planning, implementation and follow-up, and to have a large administrative capacity of adaptation to the local context.

2 PRSP Poverty Reduction Strategy Papers, prepared and drafted by governments of the partner country, in collaboration with its civil society and the international donor community

4. The guarantee of increased, sustainable, transparent and consistent financing[3]

A failing financing strategy has negative consequences on the sustainable development of the health sector and as such it is essential to provide institutional support to the health ministry and the finance ministry to develop national strategies for financing of the sector. A national health strategy must therefore include a realistic financial component. The financial framework will be drawn up in collaboration with the Ministry of Finance and other donors. Such a framework should contribute to put an end to the chronic under-financing of the health sector. It is not only a question of increasing the financial means, but also using the existing financial flow and financial mechanisms in an effective, complementary and consistent manner. In order to achieve this objective and to limit financial uncertainty, the project-focused approach will progressively be replaced by a sector wide approach (SWAp) which allows a more systematic financing approach. This is also true for the progressive building up of a social security system. Experience gathered from community health funds can be built upon to guarantee access to healthcare for the poor, women in particular; an approach which may be linked with a national financing strategy. Such an approach clearly requires political will, a transparent policy and a climate of reciprocal confidence as well as long term commitment from partner countries as well as donors.

5. Improving internal consistency between the various Belgian aid channels

The diversity of Belgian aid channels and key players is particularly striking: multilateral funds, direct and indirect federal channels, projects and programmes from regions/communities; humanitarian and 'structural' intervention work together or side by side. Dialogue and coordination must be the watchwords if the work of these various stakeholders is expected to function well and in a consistent and complementary manner with the policy of the partner country. The most appropriate aid channel or instrument to obtain the desired result has to be defined according the specific characteristics and roles of the various stakeholders. Such coordination means making maximum use of each player's comparative advantages; in view of mutual reinforcement. Coordination and consistency are paramount in the poorest countries where the country's capacity for coordination is the weakest.

5.2 The healthcare system: specific support

1. Capacity building of human resources in terms of quantity and quality

The gaps in terms of quantity and quality (technical and relational competence, sense of responsibility, motivation) of personnel, in the administration as well as in the provision of healthcare in the stricter sense, seriously impede the development of healthcare services. This is why interventions must make a structured contribution to the creation and maintenance of a sufficient number of healthcare providers who are both competent and motivated. This comprises a consistent package of measures: improved training, increased financing (including salaries), improvement of working conditions, activities aimed at fostering motivation (career planning, guidance, and housing) which can be added to structural measures aimed at reducing the brain drain. When considering these measures, it is essential to take gender aspects into account. Thus, the presence of properly trained female personnel seems to increase use of the services available among women and young people. Training and retraining also place

3 See also draft text «Duurzame ontwikkeling of financiële duurzaamheid» (Sustainable development or financial sustainability). Coprogram/Acodev, 2004 www.coprogram.be ; www.acodev.be

the emphasis firmly on the quality of dialogue between users and the community. The patient should be in the centre. The emphasis lies not only on technical quality but also on the quality of healthcare provision. In other words, it is a question of striking a better balance between «care» and «cure». Coordination with other ministries (education, finance) and dialogue with healthcare providers are also indispensable.

2. Fight against the main infectious, neglected and new diseases

The fight in terms of prevention, early treatment and follow-up of main infectious diseases such as STDs or HIV/AIDS, malaria and tuberculosis deserve particular attention, especially in the countries or regions where a high prevalence is decimating the population and placing a burden on healthcare services. In the countries which are heavily affected by the HIV/AIDS epidemic, additional means have been freed up for HIV/AIDS prevention and treatment programmes among healthcare workers. Whenever possible, all of these programmes are integrated into existing structures and activities, and this is why international contributions must have a view to reinforcing systems[4]. Those programs need also to be linked to the development of reproductive and sexual care.

Other neglected domains (as the already mentioned sexual and reproductive health) or diseases (a dozen according to the WHO) deserve our attention and the means available must be evaluated.

3. Improving the quality and use of the healthcare system

All forms of intervention (ranging from the project to general budget support - GBS) support the establishment of a sustainable and integrated healthcare system, depending on the needs pinpointed by the country in its sectoral plan. The diverse range of intervention modalities contribute to create a complementary whole: «humanitarian» and «structural» intervention, public and private sectors, «vertical» and «horizontal» programmes complement each other. Accessible, high quality and lasting primary healthcare constitutes the keystone of the system.

Belgium's support to the healthcare system, at local, intermediary and national level is aimed at assisting the authorities to resolve structural difficulties. More effective dialogue between care staff, users (the majority of them women and children) and local communities allow for better integration of the local and gender-specific needs and expectations into the healthcare system as well as reconciling supply and demand of healthcare and extending local ownership of healthcare.

4 Reinforced availability of basic pharmaceutical products

Belgium is pursuing its efforts in the international arena to encourage research into new pharmaceutical products in order to prevent neglected diseases and to improve their diagnosis and treatment. Our country can also play an active role in accessing basic medicines, as well as combating producers with bad intentions who place 'medicines' on the market with no guarantee of quality or which might even be dangerous. At the request of partner countries, Belgium may offer its experience and contribute towards better controls and regulation of the medicine market.

4 See the policy paper «The Belgian contribution to the global fight against HIV/AIDS» 2006 http://diplomatie.belgium.be/en/binaries/policy_note_aids_tcm312-65630.pdf

6. Directions of the implementation of Belgian development cooperation in healthcare

The main direction and principles set out above form the new framework for the Belgian cooperation in the health sector. This final chapter looks at the activities aimed at making these directions and principles operational within our cooperation.

Although this paper is primarily aimed at Belgian decision-makers in the field of international cooperation, advisors in cooperation and other persons responsible for dialogue with the partner country, the basic principles may also serve as a guide for dialogue for all Belgian key players. Any local intervention must provide optimal support for national efforts in putting in place a policy focused on public welfare, and aim at institutional strengthening of the healthcare system. Belgian NGOs may offer major institutional support and contribute to capacity building of local civil society organisations which ideally are expected to play an important role in realisation and evaluating the national efforts towards poverty reduction.

6.1 Promoting health, a multi-sectoral approach

In any intervention, it is important to pay attention to the fact that human development is a multi-sectoral process in which the health sector has an essential role to play as well as other sectors or sub-sectors which also have major influence on the results. In order to achieve results in the sphere of human development, a broad, gender aware and multi-sectoral approach is needed. Therefore there must be a view that extends beyond merely the health sector and the Belgian cooperation must take countries' priorities into account, the preferred areas of activity and the comparative advantages of other donors in the partner country as well as the comparative advantages of Belgium.

- The multi-sectoral response to health problems through General Budget Support (GBS), whether administered through an other donor or not, is the mode that is closest to the principles set out in the Paris Declaration. This instrument allows:
  - the country to carry out a consistent and well-balanced development policy (cf. strategic document e.g. PRSP) that provides, besides other aspects, a multi-sectoral response to health problems;
  - the Belgian cooperation to participate, through a relatively limited contribution, to political dialogue at the highest level. Thus it may take part in the decision-making process leading to more general political decisions or to political decisions in other sectors which have a bearing on the health sector: e.g. macroeconomic discussions with the IMF, civil service affairs, salaries, planning, decentralisation, privatisation, etc.;
  - identification of the need to strengthen capacity and to provide responses;
  - the sexual and reproductive rights to be taken into account during the policy dialogue.

GBS is a finance mechanism which does not automatically contribute towards an improvement in healthcare services and better health. Therefore it should be combined with a presence at sectoral level, which is closer to the operational level. Such an approach allows for the findings worked out at local and sectoral level to be relayed to national political dialogue and to influence the political decisions on the health sector at national level, for example, with regard to the development of human capital and sustainable financing.

- Choice of sectors when drafting the Indicative Cooperation Programmes (ICP). Mainly in countries where the health sector benefits from the support of several donors and where Belgium's role does not bring any significant added value, our country must contemplate supporting worth-while activities in other sectors or sub-sectors which have a direct or indirect impact on health: programmes on education, food, transport, water and hygiene, housing, water supply, agriculture and economic growth, etc.

- Cooperation with other ministries: tangible implementation at local level of a multi-sectoral approach to healthcare requires actively seeking cooperation with various other ministries aside from the Ministry for Health which are in charge of sectors linked to health (population, food, water and hygiene, etc.) or which could influence the ability to perform of the health sector (Finances, Civil Service, Planning, Education, Local Government, etc.).

6.2 Strengthening the health sector

6.2.1 Setting up a solid and responsible partnership for optimising the new (inter)national aid architecture

- On the international scene, the impact of the support granted to international institutions (e.g. WHO) as well as global funds (e.g. the Global Fund to Fight AIDS, Tuberculosis and Malaria) must be optimised and sustainable results must be ensured. This approach requires a strategic vision and evaluation of the effectiveness (efficiency) of different aid channels. This is certainly true for multilateral aid, where the implementation may work in a consistent and complementary way alongside bilateral and indirect aid without losing sight of strengthening health systems[1]. In view of the unstoppable proliferation of international initiatives in the healthcare sector, all aspects of new partnership proposals must be evaluated on the basis of the following criteria:

  1. Objectives which would be more difficult to achieve by going through bilateral or indirect aid; e.g. the development of global public goods such as medicines, or the fight against pandemics.
  2. Preference granted to programmes and institutions aimed at strengthening health systems.
  3. Global funds offering the flexibility needed to align within the country's policy and finance intervention for health system strengthening.

Furthermore, the negotiating capacity of negotiators in partner countries must be strengthened so that their voices can be better heard in multilateral negotiations and can correctly free up the available funds.

- At national, regional and local levels, a sectoral approach must be favoured, independently of the aid modality and the level of support granted. The principles of the Paris Declaration must clearly underpin any form of intervention. It must be ensured especially that there is consistent support which allows a sustainable healthcare system to be put in place. This system has to be able to supply

1 A large part of the multilateral aid consists of compulsory contributions that cannot be earmarked for specific expenditures and objectives. But in spite of this these 'core' contributions provide Belgium with the opportunity to boost the debate within the organisations and to participate in policy discussion.

accessible, high quality and lasting primary healthcare and also to effective manage the system in human and financial terms, at intermediary and national levels. The recognition of gender specific development needs between men and women enhance the effectiveness of similar system.

6.2.2 Aiming at democratic ownership, supported by society as a whole

Alignment at national level, as mentioned above, is an essential component of ownership. Nevertheless it must be insured through policy dialogue with the partner that ownership does not only concern the central authorities but that it also involves other levels (intermediary, local) and other key players within the sector. In this respect, the Paris Declaration must be interpreted in the broader sense:

1/ critical alignment to the national policy so that it responds better to the real needs of citizens and is therefore more results-oriented 2/ ownership at all levels and for all key players, 3/ accountability to the bottom as well as to the top.

Several operational fronts may contribute towards reinforcing this ownership process:

- Maintaining a solid link between the central level and operational level: this double anchorage represents an added value which Belgian key players. In this context it may be fitting to refer to the «new style projects» , which are in line with a sectoral approach. Running parallel to the strengthening of the capacities of local key players' targeted action research (local evaluation of the national strategy and development of operational strategies which flexible implements the national policy accordingly adapted to the local and gender specific needs) may contribute towards making sure that these innovative approaches are passed on to central level and thus strengthen the sector as a whole.

- Involve all partners within a sector: in a system as complex as the health sector, each operation has to clarify and clearly lay down the relations between the various stakeholders: aside from internal relations, there are relations between central and operational levels, between central and local authorities and civil society, between public services and other operational partners such as NGOs and the private sector, between operational partners and academic institutions, between the health sector and other sectors and between various ministries. This approach, which also strives for juridical, political and social gender equity, reinforces local ownership and sustainability. The attention paid to different functional and/or formal relations between the stakeholders has repercussions on the methodology and technical assistance (see below).

6.2.3 Supporting result-oriented health plans according to a sector wide approach

The Belgian cooperation with the healthcare sector must always aim to support the sectoral policy of the partner country (Sector Wide Approach or SWAP-approach). This result-oriented support to the overall development plan of the sector (established by the country, and including rules for implementation, monitoring and evaluation agreed between donors), may take the form of «sector budget support» (SBS) at national level but also, with a view to a portfolio approach, of complementary support at sub-national or operational level.

Specifically:

- In the countries where the sector-wide approach (SWAp) is properly developed and bears fruit, Belgium must aim at getting involved or even to take the lead in the health sector. In the priority partner countries, Belgium must develop the capacity needed to take on or preserve this driving role.

- In the most important partner countries where the government is not (yet) capable of drafting a SWAp at sectoral level, Belgium must be prepared to play a proactive role in order to progressively strengthen the country's capacity in both managing the sector and coordinating the various key players. Therefore it may be possible to examine the possibility of putting in place, at sub-national or sub-sectoral level, a limited sector-wide approach (mini SWAp) which would allow for better coordination of the investments from various donors.

6.2.4 Participating in the development of sustainable financing mechanisms

Sustainable financing mechanisms should be developed to allow the partner country to put in place a consistent policy over the long term. This means that:

- Efforts must be made in terms of volume (to achieve 0.7%[2]) as well as towards predictability of funds in the long term (15 to 20 years).

- The financing must aim to strengthen the whole sector as well as the relations between key players inside (and outside) the sector. This objective requires sufficient flexibility to opportunities that arise over the course of the intervention and to follow the dynamics in this sense. The traditional aid project framework is too rigid and too isolated to respond effectively to these challenges. The portfolio approach and more openness to flexible planning and monitoring methodologies seem to be more fitting strategies. Nevertheless it requires creativity to get at the same time the flexibility needed for the dynamics of the health sector development in the partner country and to respond to the requirements of Belgian legislation.

- The financing of a SWAp-approach requires the adoption of a critical attitude and that financing modes may vary from Sector Budgetary Support or basket fund to projects). This is why a portfolio approach which involves several of these instruments in a consistent and complementary way may represent an interesting approach in the spirit of mutual reinforcement. This approach places different forms of financing on an equal footing and draws upon their complementary aspects. Reinforcing capacities simultaneously at central and at operational level and interaction between both levels are essential factors.

- Particular attention will go to gender budgeting and budget tracking.

2 Where the OECD countries aim to spend by 2015 on average 0.7% of their GDP on ODA (Official Development Aid), Belgium toke the firm decision to reach this level already by 2010.

6.2.5 Targeting improvement in cooperation between Belgian stakeholders

With all due respect to the identity of each stakeholder and without wishing to abuse the process, we must encourage better cooperation between Belgian stakeholders. Below are some suggested routes:

- Recognising and clearly describing the role of each player.
- Encouraging regular meetings in Belgium (e.g. Be-cause Health, medical NGOs - DGD) as well as on the ground.
- Increase the involvement in the preparation of Indicative Cooperation Programmes and in the identification of direct cooperation in order to carry out joint programming from the beginning. This requires some simplification of procedures.
- Proactively promote the possibility of introducing joint tenders in public international markets.
- Reinforce the role of civil society organisations (CSO). Aside from reinforcing the capacity of public bodies, the necessary means must also be freed up in order to strengthen the capacities of local civil society players, either through our NGOs or others whilst taking the gender dimension into account. Civil society has an essential role to play in the critical or optimal alignment. There must be proper arrangements on the mechanisms used to dialogue with authorities and Belgian key players.
- Make use of a flexible methodology: the Belgian Cooperation must remain open to using other instruments than the logical framework. An alternative methodology[3] is often more suited to understanding a complex environment such as a health system, for supporting the local process and promoting high quality work. The administration must be at the service of the development process and not the other way round.

The expertise and on the ground knowledge from Belgian international cooperation in the health sector have gained international recognition. These assets, however, are sometimes not systematically capitalised on or not well publici-sed. Better use of past experiences would have prevented mistakes and might have increased the impact of this expertise on developments within the healthcare sector at international level. This explains the need to be able to adopt a long term strategy for developing and making use of an institutional memory.

6.3 Reinforcing the healthcare system

6.3.1 Promoting training of healthcare staff in higher numbers and of better quality

With a view to capacity building of human capital and outlining sustainable national human resources plan, the Belgian cooperation may, through specific programmes and policy dialogue, provide support to the following activities:

- Encourage the build-up of attractive human resource environment, first of all in rural areas, by putting in place or refining strategies focusing on the staff performance. Past experience in this domain should be utilised.

3 Next to the logical framework one should be open to alternatives such as outcome mapping, or «chain of effects» (GTZ).

- Participate in a training policy based on the following principles:

  - Greater awareness, in training and continued training, of interpersonal skills and «change management» as opposed to traditional management skills;
  - Greater attention for training and continued training, of healthcare focused on the patient as opposed to purely technical skills;
  - Preference given to training at the working place and encouragement of peer review mechanisms;
  - Promoting South-South exchanges;
  - Greater attention for the gender dimension and encourage training of female health workers, in particular in rural areas.

- Contribute towards curbing the brain drain at Belgian and European level.

Within this framework of institutional capacity building, there must also be an evaluation of the policy on Technical Assistance (TA):

- TA must be adapted to the needs of the partner country and the activities of other donors. The added value that Belgium has to offer in this respect primarily lies with the existing link at operational level, regardless of the level where the TA is being allocated (locally or centrally). In this perspective, the TA approach continues to take on major importance in terms of a technical contribution to a legitimate policy dialogue.

- The profile of the technical assistant must be more centred on transformational capacities (systems thinking, critical analysis by means of explicit models, action research) and interpersonal skills (facilitator, negotiator, flexibility, and networking). Technical skills remain important and have to be based on capacity building and not on directly supplying healthcare. Managerial tasks must be delegated whenever possible.

- Revaluing Technical Assistance for clinical tasks as one of the strategies (in the short term) in countries where there is a severe lack of healthcare staff.

- The pursuit of an approach which actively takes into account the gender dimension would contribute to better quality TA.

6.3.2 Optimal integration of the fight against specific diseases in the healthcare system

Although the decision to support programmes which combat specific diseases may be justified in certain cases, it is important nevertheless to establish some priorities among the numerous initiatives which already exist, «global» or otherwise, on the basis of a consistent set of criteria. The following principles must especially be taken into account:

- the Guarantee of access to high quality healthcare in relation to specific diseases which need particular care difficult to integrate;
- the level to which these programmes offer a long term guarantee that they reinforce the local healthcare system rather than destabilise it. Studies[4] have shown that an efficient healthcare system improves the effectiveness of the specific programmes;
- the experience and expertise of Belgian international cooperation in relation to certain diseases;

4 Nick Lorenz, Swiss Tropical Institute, presentation Madagascar, October 2007.

- the impact Belgian international cooperation may have through its support of a specific programme. As financial impact will be often difficult at the global program level, a niche in a specific programme must be clearly identified.

6.3.3 Improving the quality and accessibility of healthcare

- Choice of programmes which support access to high quality healthcare (technically as well as relationally) in the first, second and (where appropriate) third lines. Among the fundamental criteria for approving these programmes, aside from the measure in which they support the «provision of medical services», there is also the extent to which they can allow the development of operational strategies which are capable of reinforcing the national policy.

- Programs of prevention, promotion, education in health, screening and vaccination make all part of the global healthcare package on which everybody (M/F) has right.

- Accounting for quality in healthcare systems must also be a concern of humanitarian aid in delicate circumstances or situations of conflict. In this respect it is important, in a long term vision, to analyse existing healthcare services as much as possible to maximise possible benefit from local economic opportunities (e.g. in the field of food aid) and cooperation with other key players. Besides, there are a high number of intermediary situations[5] which lie between immediate emergency aid and a situation which allows for sustainable development. The humanitarian aid strategy must ensure, wherever possible, that there is a smooth transition from an emergency situation to a more stable form of cooperation.

6.3.4 Making essential pharmaceutical products available

The key players in the international healthcare sector have the duty to advocate and actively become involved in widening access to good quality pharmaceutical products (diagnostic products, medical equipment and medicines in particular). Priority activities are suggested in the conclusions of the 2007 Be-cause Health Seminar «Drugs, cure or curse»[6]: The main recommendations are briefly mentioned below:

- Encourage Research and Development (R&D) of necessary medicines, while recognising and encouraging the role of partner countries in terms of expertise and resources.

- Support the countries that wish to make use of the flexibility measures set out in the TRIPS agreement[7]. Their principle is that the speed of accessing certain medicines takes precedence over patent rights. Belgian development cooperation must defend the extension of this list to include all essential medicines needed for providing primary healthcare[8].

5 Wim Van Damme http://heapol.oxfordjournals.org/cgi/content/abstract/17/1/49
6 For more details see www.be-causehealth.be (Seminar 2007)
7 TRIPS: Trade Related Aspects of Intellectual Property Rights (Doha WTO Declaration 2001). The principle is that for some medicines (HIV/AIDS, TB, malaria) their speed of access takes precedence over patent rights. Belgian international cooperation advocates the extension of this list to all essential medicines that are required to guarantee primary healthcare.
8 In accordance with the resolution of the 58th World Health Assembly (WHA), in May 2005.

- Proactively promote strategies that enhance the quality of pharmaceu-tical products: controlling the quality of exported medicines, application of European Union directives on the subject, charter for distributors, joint audits of producers for assuring quality and the development of pharmaceutical vigilance systems at international level (e.g. WHO prequalification system) or in partner countries (purchasing centres, distribution chains and development of national pharmaceutical inspections) and raising awareness among the international community to the consequences of using poor quality products.

- Involvement in mechanisms that guarantee financial accessibility to medicines, also for the poorest and most vulnerable segments of the population as women in rural areas.

- Participate in long term strategies which encourage the rational use of medicines, both at individual and national level.

6.4 Exit strategy in the framework of bilateral cooperation

In countries where the Belgian cooperation no longer wishes to involve itself as a matter of priority in the health sector, thought must be given to whether it can withdraw from the sector without harming the sustainability of the intervention or the sector itself. This procedure requires meticulous planning. On one hand, the extent to which the partner country is capable of continuing the activities underway must be looked at, in terms of budget and content, and on the other hand thought must be given to which other financial backers can and/or eventually wishes to take over our support activities. Delegated cooperation via partners in the European Union could be an interesting possibility to explore. But such an approach requires very open dialogue with the partner and must not give the impression that Belgium is shying away from its commitments unilaterally but that the aim is to optimise the aid envelope in its entirety.

Conclusion

One principle:

Right to health and healthcare

Nine lines of force:

A. Strengthening the health sector through

1. An international partnership which strengthens the system
2. Democratic policy planning and implementation
3. A sector-wide portfolio approach
4. A sustainable financing system
5. Consistent commitment from Belgian aid channels

B. Strengthening the healthcare system by

6. Strengthening human resources for health
7. An integrated fight against neglected and specific diseases
8. Universal access to high quality healthcare
9. Availability of essential pharmaceutical products

One result:

The development of a healthcare system which offers accessible and global high quality healthcare on an efficient and sustainable basis, responding to the needs of the whole population and thereby contributing to poverty reduction and improving the general standard of living of people.

Annexe

The Antwerp Declaration

We call on national governments, international organisations, all agencies and individuals concerned with health and development to

1. Recognise access to healthcare for all, requiring adequate human resources, infrastructures, essential drugs and commodities, as a basic human right, and as essential for the control of the poverty related diseases;
2. Acknowledge the need for multi-sectorial approaches to reduce the burden of HIV/AIDS, tuberculosis, malaria, and other infectious and non-communicable diseases;
3. Ensure that specific disease control programmes strengthen regular health systems and that they are co-ordinated with other programmes and interventions;
4. Ensure that health systems are responsive to the needs and expectations of the populations, benefit from fair and sustainable financing and contribute to improving health outcomes;
5. Strengthen in partnership the financial, logistic, operational and scientific capacities of the low-income countries to improve their health services and disease control programmes, and to orient international research to the needs of the people and the health systems;
6. Facilitate and encourage the development and management of human resources in the health sector, and ensure that market mechanisms allow and promote global access to essential drugs and health-promoting commodities;
7. Share this declaration and the goal of «Health CARE for All» as a common agenda behind which all stakeholders can unite.

This declaration supports all health initiatives to realise «Health for All» and renews the commitment of the International Community to provide «Health Care for All».

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